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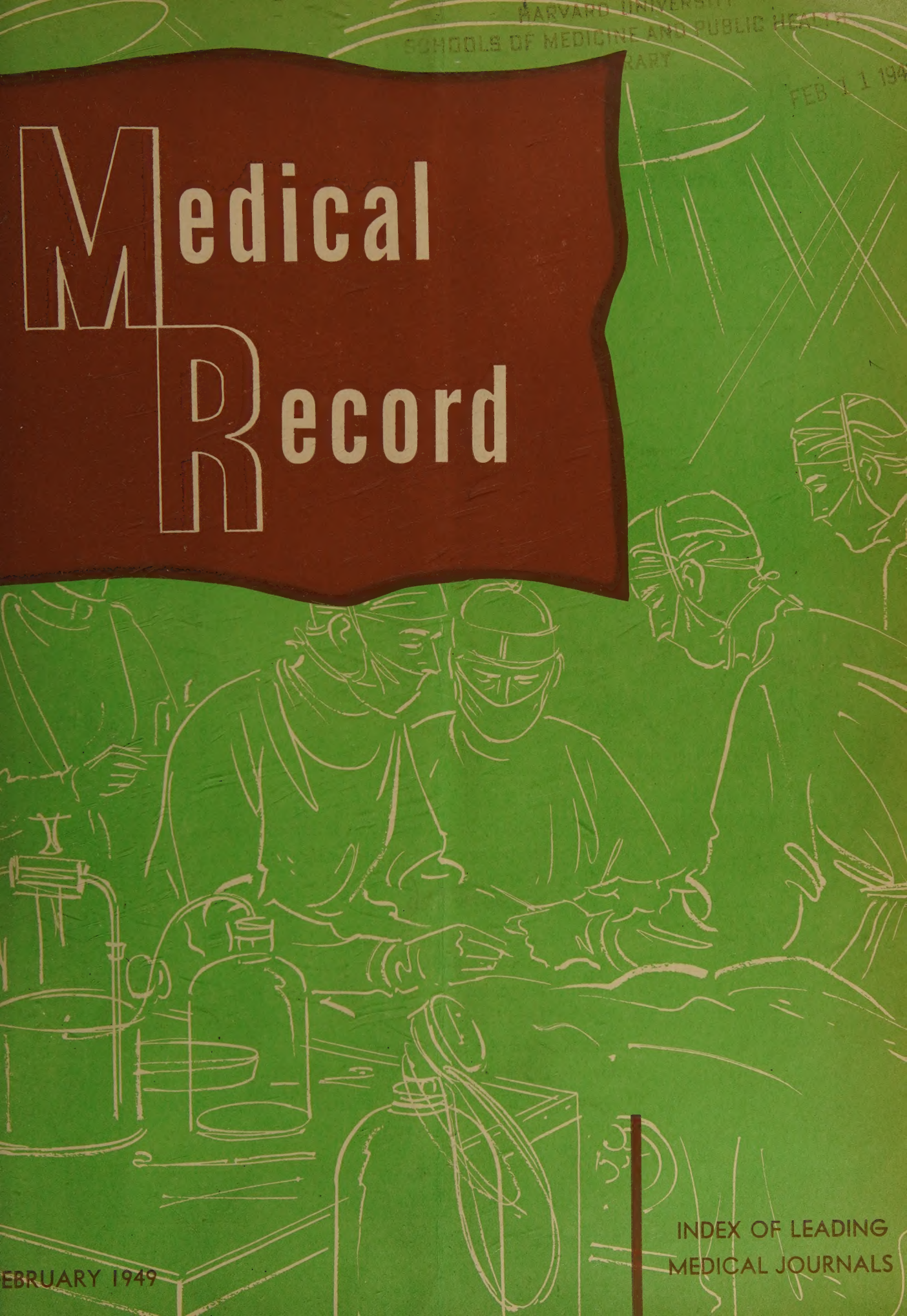

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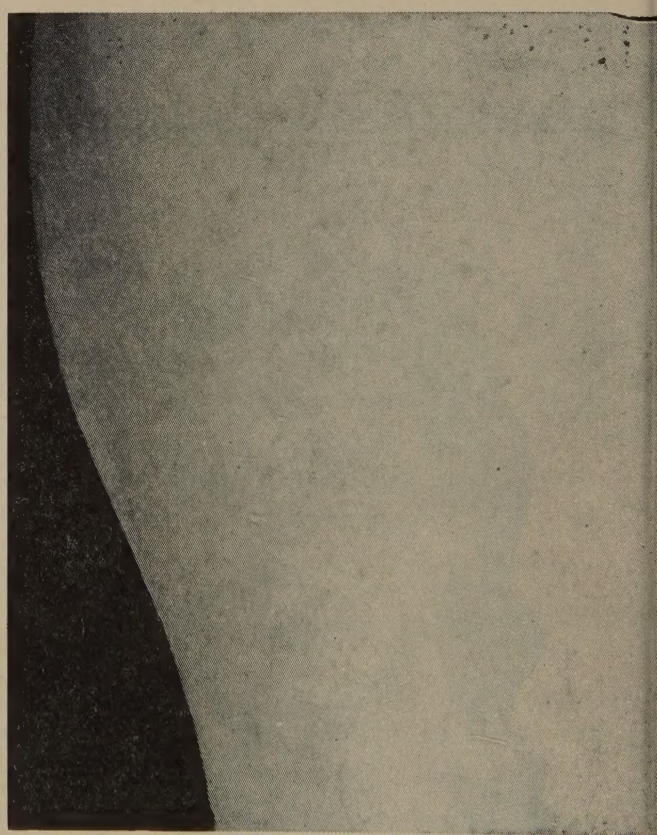

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FEBRUARY, 1949

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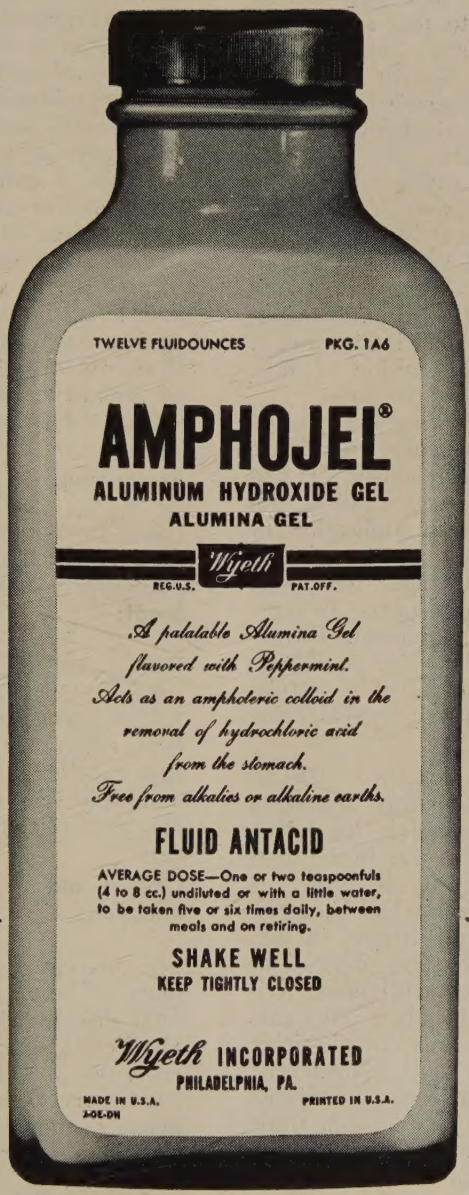
IN THE MEDICAL MANAGEMENT OF PEPTIC ULCER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Critique

Fletcherizing: The old Fletcherizing fad, which still retains some vitality, was exhaustively examined by Harold H. G. Holck, who published the results of his studies in a booklet from University of Chicago Press in 1929, entitled *Diet and Efficiency*. In his preface to this monograph Dr. Anton J. Carlson remarked man's singular ability to live on most diverse diets and he expressed regret at the money and energy expended upon dietary faddery and not devoted to valuable nutritional studies. Holck's main rules were: (1) Eat only when actually hungry; (2) stop eating when satisfied; (3) chew foods well; (4) eat foods for which you have a craving and do not eat those that are repulsive. He heroically continued his carefully controlled self-experimentation for 75 weeks and found that it required him twice as long as usual to masticate a thousand calories, but his food intake was at minimum, and its percentage composition of fats, protein, and carbohydrate was nearly the same.

Holck also Fletcherized by chewing excessively. He found that this decreased muscular endurance, typewriting accuracy, and basal metabolism. It had no significant effect on blood pressure, pulse, oral temperature, sleeping time, mental multiplication, or typewriting speed. It induced improvement in efficiency in solving chess problems and the body weight tended to increase, but the decrease in muscular endurance was regarded as significant. Fletcherizing was judged to be of little value to human beings, chess players excepted, and that is a relatively limited sphere of activity rarely guaranteeing a livelihood.

Tobacco therapy: Way back in its March 15, 1930 issue the *Journal of the American Medical Association* felt that tobacco advertising had gone mad. This was in the matter of dragging the health angle in by the heels. A large number of American physicians had been circularized by Lucky Strikes' manufacturers to find out whether they regarded the "toasting process" as likely to free these fags from harmful throat irritants. Each physician was thoughtfully given a carton of the cigarettes, of course. But not one physician in 10,000 could answer this question competently. A little earlier the chubby gals had been admonished to reach for a Lucky instead of a sweet, but trade protests caused the discontinuance of that appeal. So the gal with a double chin no longer became slender by smoking. Then there was Cremo Cigar advertising that it was not "spit-tipped." Advertising of this kind was pronounced socially and hygienically pernicious.

Who discovered vitamins? In a report entitled "Nutritive Properties of Substances which Contain Nitrogen," published in 1816, Magendie showed that dogs could not live on fats, sugar, and water, but must have some form of nitrogen. When he fed dogs sugar and water their weight steadily declined, strength diminished, appetite became less keen and liveliness vanished. Then small ulcerations developed in the center of the transparent cornea, first on one eye, then both, and increased rapidly; soon the cornea was pierced and the eye fluid began to flow out. Magendie repeated these experiments and thus presented to posterity a clear picture of nutritionally developing xerophthalmia.

In order to test the nutritive value of fats, a diet of olive oil and water was fed another dog which died but did not develop xerophthalmia. Magendie appeared to realize that he was dealing with dietary deficiency; he found normal chyle in the animals on autopsy. Furthermore he recognized that analogous conditions in man came about as a result of a restricted diet. He told of a physician who tried to live on sugar exclusively for a month, but who had to give up the experiment because he became feeble and bloated, and livid red spots appeared on his eyes, soon after which he died. C. M. McCay believes that Magendie not only discovered the need of protein in the diet but was also the father of the vitamin hypothesis.

Art of prescribing: Are interns and student doctors taught how to prescribe these days, or are they encouraged to place reliance on ready-prepared mixtures, essentially doctors' patent medicine, advertised on blotters and recommended, with samples, by fluent detail men?

Ergot: Said T. Sollman in the third edition of his *Manual of Pharmacology* "when proper doses are used during labor, with the os fully dilated and no obstruction, they tend to hasten *normal delivery*. Really effective doses, however, are rather dangerous to mother and child. The firm contraction may hinder delivery, and compress and asphyxiate the fetus; even rupture of the uterus has been reported; but these accidents are very rare."

Chalice and infection: Jane Walker M. D. discussed "The Communion Chalice and Infection" in *Medical Officer* for May 3, 1930. She advocated a double chalice to avoid the possibility of becoming infected with some loathsome or fatal disease while taking communion. She and a Dr. Percy Dearmer had designed one made of beaten silver in two compartments. The advantages cited were cleanliness, speed of administration, efficiency, and expediency, there having then been a clerical shortage in Britain—accordance also with modern practice and habits of hygiene. The wafer was to be dipped in the liquor and then shoved into the communicant's mouth. Separate cups for each communicant had no appeal to Dr. Walker at all. She held that the objection to putting the wafer on the communicant's tongue was trivial.

Vitamin in tea: A few years ago manufacturers and merchants began to advertise that green tea contained appreciable and useful quantities of vitamin C. Helen S. Mitchell reported on this in the *Journal of the American Dietetic Association* for June 1929. She concluded: "The results of the experiments reported herein lead us to conclude that there is no demonstrable amount

of vitamin C in green tea. In view of the current advertising of Japan green tea, it is recommended that commercial advertisers make sure that the experiments upon which they are basing their statements are scientifically accurate and that this advertising text does not permit of a wrong interpretation by the public."

Native morals: Albert Londres in his book, *A Very Naked People,* tells of an African who desired an indemnity from his brother with whom he had left his wife while he spent two years in France. When he returned he expected a son only to find, to his chagrin, that his brother had not slept with the woman. The brother complained he did not like her but his oversight cost him three goats. In another case brought before the court a husband wanted his wife forbidden to bring her lovers home but to collect ten francs apiece from them when she met them outside. Another man married his mother off in return for a cow but the bridegroom returned her saying she was worth only a goat. The native jury doubted that she was worth that much. Finally, a husband demanded very sensibly that his wife's lover cultivate his fields for a month to compensate for having had intimate relations with her at frequent intervals.

Irreplaceable scientists In the *North American Review* for January 1930, E. E. Free named what he regarded as the ten irreplaceable scientists whose loss would be irreparable. Conventional history is rich in apochryphal Listers, Pasteurs, Oslers, and Erhlichs, and to the lay mind they were all wizards. But Free should have read B. J. Stern's *Social Factors in Medical Progress.* By convincing argument Stern showed that clinical inventions and discoveries were determined purely by rises in the general cultural level, and he cited hundreds of duplications in discovery—ten practically simultaneous inventions of the laryngoscope and five independent discoveries of adrenalin; eight simultaneous discoveries of the cellular basis of life; three manifestations of artificial immunity following inoculation with attenuated cultures of anthrax bacillus; five officially recorded demonstrations of the clinical value of cowpox vaccination before Court Physician Jenner hogged the limelight; three simultaneous demonstrations of vasoconstrictor nerves, and five independent introductions of ether. The ophthalmoscope was invented simultaneously in Germany and in England.

The agglutination of typhoid bacillus was independently discovered in England and France, and the cause of amebic dysentery independently in Austria, Russia, Egypt, and the United States. The sphygmomanometer was independently invented in Italy and England, and ten years later was simultaneously improved in Germany and in France. The chemical nature of respiration was worked out simultaneously in Holland, Sweden, Italy and France, and the hypodermic syringe was independently invented in Ireland, France, and Scotland. Hence the premature removal of many distinguished individuals would have delayed discoveries or inventions attached to their names by less than a year—often not at all!

Had Jenner been removed prematurely cowpox inculation would have been removed to Schleswig-Holstein. Pasteur's removal would not have retarded the development of bacteriology, but would merely have shifted the scene to Germany or England. Lister's premature death would have given the American, Guerini, the limelight, and so on.

Again, Richet was given the Nobel Prize for his duplication of Rosenau and Anderson's rediscovery of what has long been referred to as the "Theobald Smith phenomenon," for a decade earlier, without claiming priority, Theobald Smith knew this same thing had been described by others as early as 1838. Banting was honored for his confirmation and popularization of the work of a Chicago physiologist who, unknown to the press, a decade earlier had prepared and tested insulin without claiming credit. d'Herelle was glorified for his "bacteriophage," but he merely confirmed and popularized the well-known transmissible bacterial lysin of Twort. Widal, immortalized in the Widal reaction, actually was popularizing Gruber's confirmation of Greunbaum's discovery of a reliable diagnostic test for typhoid fever.

Diathesis: Diathesis has been called "predestination in disease." W. Langdon Brown discussed the subject in the *British Medical Journal* for March 22, 1930. Whereas diathesis had been heard less frequently, science was then bringing the word back into fashion. Diathesis lapsed when belief in scrofula and struma became untenable; then inborn errors of the metabolism, idiosyncrasy and endocrine imbalance were bringing the term back into circulation. It is "any condition of prolonged peculiarity of health giving proclivity to definite forms of disease." The failure to distinguish between liability to tuberculosis and infection by the bacillus led to much error. The belief in malarial diathesis about overthrew the doctrine—also the attribution of leprosy to eating unwholesome fish! (Who fished that one up anyway?) Weismann placed the foundation for the newer pathological predestination in the germ plasm. Next Draper at Columbia tried by measurements to find gall bladder, peptic ulcer, and pernicious anemia facial types. Albinism, alkaptonuria, cystinuria, pentosuria, and porphyrinuria are common. Metabolism in such individuals stops short of normal, lacking some enzyme, and product is excreted as a byproduct. In albinism the subject cannot manufacture the proper blood and bile pigment; haemophilia was also described in this article as a dread disease caused by lack of a certain ferment.

Medical patents Discussing medical patients in 1930, the *Lancet* said that things like insulin, vitamin D, and so on are really discovered gradually by a large number of individual workers often in various countries, and that any patent is unfair in that it gives to those who happened to make the last push over the top more credit than it gives earlier and perhaps even more important and gifted workers. The vitamin D patent granted to Wisconsin workers absolutely

(*Continued on page* 10)

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In a recent coast to coast test of hundreds of people who smoked only Camels for 30 days, throat specialists, after weekly examinations, reported:

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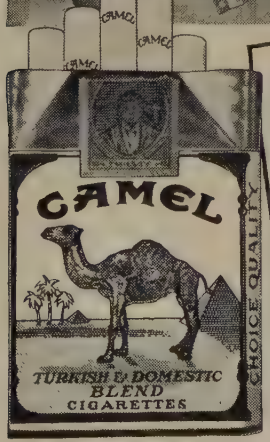

According to a Nationwide survey:

MORE DOCTORS SMOKE CAMELS

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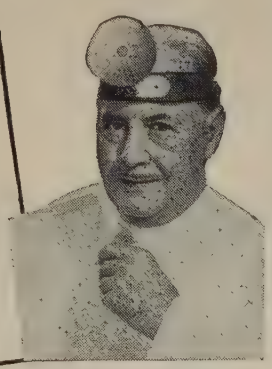


Doctors smoke for pleasure, too! And when three leading independent research organizations asked 113,597 doctors what cigarette they smoked, the brand named most was Camel.

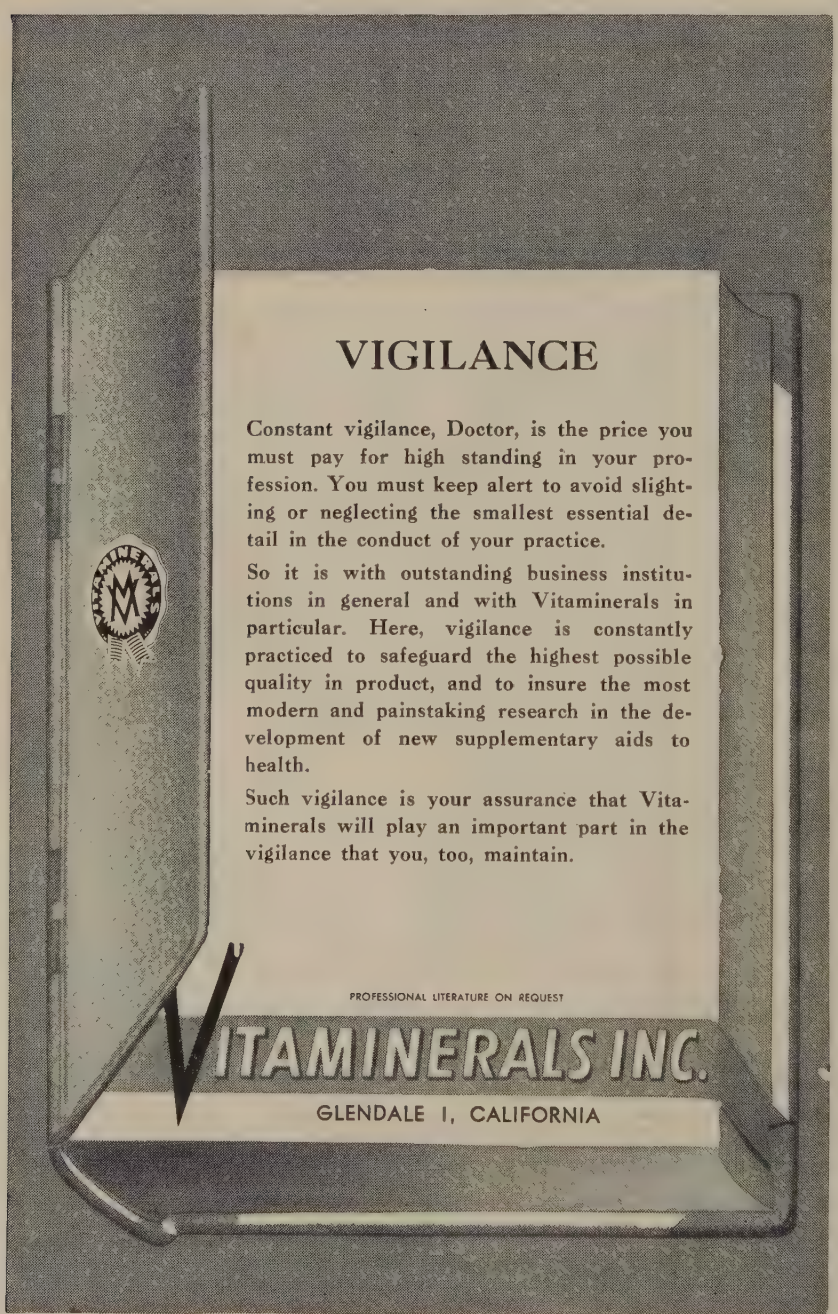
(*Continued from page 7*)

ignored British workers in the same field and later absorbed the irradiation of ergosterol. There should be no patents of medical discoveries; instead they should be dedicated to the public. Their administration should thereafter be in the hands of a State medical patents trustee. The first free license for manufacture should be granted to a manufacturer nominated by the final discoverer and in his own country; thereafter licenses should be issued on a fee basis insofar as warranted, the public good always being paramount. The full and free interchange of knowledge by all research workers in all lands at all times should be encouraged at all costs.

Athletics Lancelot R. Lempriere wrote in the *Lancet* for March 29, 1930, certain cautions about athletics which might still come to mind. He said there was much abuse of games in the schools and that he noted the deleterious effects of exercise two decades previously—especially violent exercise. He felt that adult control must be exercised to curb game crazes. He noted a number of fatalities, usually accidental, as well as general fatigue, lassitude, diminished or inferior intellectual output, and loss of weight as common results of excessive exercise. He thought exercise should not be resumed until three days after any illness. He said that high intelligence and high athletic skill did not go together. Moderation was the keynote.

Pellagra Correcting a note by Wilson in the *British Medical Journal,* W. R. Aykroyd, in the April 5, 1930 issue of the same journal, rehearsed the scientific literature which unfounded the protein-deficiency theory of the etiology of pellagra (which is now partly reestablished in a different way) and concluded by giving references to work by Goldberger and others which favored the vitamin-deficiency theory. He concluded: "While the question is still open, the evidence at the moment seems decidedly against the theory of amino-deficiency. Investigation of the distribution and properties of vitamin B_2 seems a promising line of attack, though at present it would be premature to regard vitamin B_2 deficiency and pellagra as synonymous." We have by now about boxed the circle and proteins, amino acids, and vitamins all seem to be involved in the production and cure of pellagra.

THE CRITIC.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MEDICAL RECORD

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VOL. 162, No. 2. FEBRUARY, 1949 WHOLE No. 2792.

DOCTOR ABRAHAM LEVINSON

On the Occasion of his Sixtieth Birthday on August 25, 1948

SOLOMON R. KAGAN, M. D.
Roxbury, Mass.

One of the colorful figures in contemporary medicine is Dr. Abraham Levinson of Chicago. He is a clinician, research worker, teacher, historian and humanitarian. He has left an indelible impression on pediatrics and historical literature.

Dr. Abraham Levinson was born on August 25, 1888. He received his M. D. degree in 1911 from the University of Illinois College of Medicine, his B. S. degree in 1917 from the University of Chicago, and pursued postgraduate studies abroad. He has been associate professor of pediatrics at Northwestern University Medical School; professor of pediatrics at the Cook County Graduate School of Medicine, and attending pediatrician at the Michael Reese, Cook County and Mt. Sinai Hospitals of Chicago. He was vice-president of Michael Reese Hospital (1933-35), vice-president of Mount Sinai Hospital (1934-36), vice-president of the Chicago Pediatric Society (1935), president of the same society in 1936 and chairman of the Committee on Mental Hygiene of the Illinois State Medical Society, 1947-48. He has been a member of numerous medical and scientific societies here and abroad.

Dr. Levinson has made fundamental contributions to pediatrics. He has described several syndromes and devised several tests bearing his name. He described an auscultation phenomenon known as the Levinson phenomenon, presenting a sign for differential diagnosis between laryngeal diphtheria and laryngitis (1915). He devised a tongue depressor which is of value in the examination of premature infants (1914), a spinal puncture needle and a manometer (1919).

He was the first to describe: localized meningitis (1923), unilateral symptoms in meningitis (1928), acute transitory cerebral manifestations (1928), and hemorrhagic encephalitis (1935).

He has made an experimental study on the role of the liver in hippuric acid synthesis (1918); a hematologic study of influenza (1919); a clinical study of craniotabes (1921); and of pulmonary tuberculosis in children (1925); an experimental study of intrathecal administration of chemicals (1931); and a histologic study of the meninges in intracranial hemorrhage of the newborn (1933).

Dr. Levinson is best known for the following original work in the study of cerebrospinal fluid: the Levinson test—a test for the diagnosis of tuberculous meningitis (1917); the Ph of cerebrospinal fluid showing that the reaction of the cerebrospinal fluid under the normal condition is the same as that of the blood (1917); cataphoresis of cerebrospinal fluid (1917); the cell bacteria ratio in the cerebrospinal fluid (1919); a comparison of lumbar and cistern fluid (1936); a quantitative glucose method (1936); the enzymes of cerebrospinal fluid—a new field of study in the physiology and pathology of cerebrospinal fluid (1939). His first paper "Practical Points in the Diagnosis and Treatment of Diphtheria" appeared in *The Medical Record*, January 6, 1912.

In addition to his research work, Dr. Levinson has written on the psychological and sociological aspects of pediatrics, such as the psychology of the sick child, the psychological state of the mother and the grandmother and convalescence in children. He has also written on popular medicine with special reference to prevention of disease, particularly on the prevention of tuberculosis and heart disease.

Dr. Levinson is the author of the following books: "Cerebrospinal Fluid in Health and in Disease"—the first book on the subject to be published in the United States. This standard book, which originally appeared in 1919, has gone through three editions. "Examination of Children by Clinical and Laboratory Methods"—a text book for students (1st edition, 1924; 2nd edition, 1927). "Pediatric Nursing"—a text book for nurses (1st edition, 1925; 2nd edition, 1933; 3rd edition, 1945). The book was translated into Hebrew in 1933 and was used as a text for nurses in the Hadassah Medical Organization in Palestine. "Tobias Katz" (1924), a chronicle of a wandering Jewish physician and encyclopedist of the early 17th Century. "Pioneers of Pediatrics" (1936), a history of pediatrics. He also contributed the following chapters and sections to various books:

"Infant Feeding" in Heineman's *Milk* (1919); "Cerebrospinal Fluid" in Abt's *System of Pediatrics* (1923); "Tuberculous Meningitis" in *Clinical Tuberculosis* (1935); "Cerebrospinal Fluid and Meningitis" in Brennemann's *Practice of Pediatrics* (1936, 1939, 1942).

Dr. Levinson has made many original contributions to medical history. His monograph "Pioneers of Pediatrics" abounds in colorful data about the development of pediatrics. His monograph "Tobias and His Work" mirrors medical progress in the early seventeenth century. His "Early Studies of Cerebral Function" gives a comprehensive view of the history of the brain function through the centuries. His "History of Tuberculosis" traces the history of this disease from Biblical to modern times. Another medicohistorical contribution is Dr. Levinson's paper "The Three Meigs," father, son and grandson, who aided materially in the development of American pediatrics. Ehrlich, Koch, Metchnikoff, Billard, Jacobi, Neuburger, and many other notable figures have been made the subject of articles on medical history that have come from the pen of Dr. Levinson. A unique contribution to medical history is also Dr. Levinson's papers on Child Welfare (1931); Medallions and Plaques of Interest to Pediatricians (1941), and Medical Medallions (1943).

Dr. Levinson was editor of *Medical Leaves* (1939), editor of the Memorial Issue in honor of Dr. Charles Spivak, (1927) and co-editor with Dr. I. A. Abt of the *Pediatric Year Book* (1916-1920).

In recognition of Dr. Levinson's important accomplishments, the following awards from local and national societies were given to him: Certificate of Honor, Class I, for his scientific exhibit on Cerebrospinal Fluid in Health and Disease, by the A. M. A. Convention in 1932; Certificate of Merit, Class I, by Illinois State Medical Society in 1936, for his exhibit on Experimental Studies in Cerebrospinal Fluid; Certificate of Merit, Class I, by Illinois State Medical Society in 1940, for his exhibit on cerebral manifestations of the newborn. He was also given the Phi Lambda Kappa Gold Medal award for achievement in medical sciences in 1940 and the orator key of the History of Medicine Society of Tulane University Medical School in 1942.

In 1948, a Celebration Committee in honor of Dr. A. Levinson was organized. The Committee is publishing an "Abraham Levinson Anniversary Volume." This volume which includes original articles on pediatrics and medical history is edited by the writer, and will appear in 1949. The writer joins numerous friends and colleagues of Dr. Abraham Levinson, in wishing him many years of good health and literary productivity.

We say: Dr. Levinson ad multo annos!

176 Seaver Street

OBSERVATION ON THE USE OF SODIUM AMYTAL IN THE TREATMENT OF APHASIA

BENNETT W. BILLOW, M. D.
New York, N. Y.

There is a paucity of literature on the use of sodium amytal in the treatment of aphasia. It was Drs. Linn and Stein (1) who, while on medical duty in North Africa, first brought attention to this form of therapy. They found motor aphasia improved suddenly and dramatically after intravenous administration of sodium amytal on a group of wounded patients with disphasia following wounds of the dominant cerebral hemisphere.

The writer had occasion to consult with Dr. I. Wechsler, the neurologist, concerning a case of right hemiplegia associated with mixed aphasia. He suggested that I try sodium amytal on this patient. A few weeks later a similar case presented itself. The purpose of this communication is to report on the use of sodium amytal on these two patients. Any medicament or procedure that can assist or hasten the amelioration of our patients, or afford us the opportunities of studying our patients better, should be a welcome addition in the armamentarium of the physician.

Report of Cases

Case No. 1 A hypertensive woman of 46 was seized with a right hemiplegic attack associated with mixed aphasia. The patient was mute when first seen. Her comprehension was practically nil and she could not execute the most simple instructions such as sitting up, shaking hands, etc. Within approximately 10 or 14 days, she regained slight use of her limbs, her comprehension improved; however, she was still unable to utter a sound. A few days later, she was seen by Dr. Wechsler who recommended we try sodium amytal. She was given a 5 per cent solution of sodium amytal intravenously at a slow rate. After about 3½ ccs. of the solution, the patient began to utter a few sounds such as her husband's name, the day of the week, and responded with the word "fine" upon being asked how she felt. The family reported that she appeared to be in a better frame of mind all during the rest of the day, and that she made continuous efforts to speak. However, during the following week, there was slight or little improvement. The injection was repeated in the same manner again, and this time she

clearly enunciated the writer's name, she reached the two word level of speech, and attempted to carry on conversation. After two more injections (the fourth injection), there was a noticeable improvement in her vocabulary, her enunciation became more distinct. However, her conversation did not go beyond the level of two word phrases. There was no improvement after two more injections and treatment was terminated. At this writing, the patient's speech has not advanced beyond the level of the fourth injection.

Case No. 2 The writer was called in to see a 73 year old woman who was found mumbling on the floor. Physical examination revealed a blood pressure of 190/106; her left limbs were completely paralyzed; she was mute; she made frantic efforts to speak, however, no intelligible sounds were forthcoming. She was taken to the hospital where the writer gave her an intravenous injection of sodium amytal, using the same technique as described in the first case. The patient showed remarkable improvement, she began to speak in single words, they were pronounced distinctly, and her mind was clear. The author reexamined her several hours later and found her condition the same. Sodium amytal was repeated, and this time she spoke in sentence like structure and executed instructions given her. Both the nurses and I were tickled pink at this continued improvement. However, later that night, the nurse called dismally with the news that "she's back again at the single word state." She was given four more injections. Since no further improvement was seen, sodium amytal therapy was stopped and the patient continued to speak in monosyllables. Seven days later the patient had another stroke, developed bronchial pneumonia and died of heart failure.

Comment

It is difficult at this stage to come to any definite conclusions as to the efficacy of sodium amytal in the treatment of aphasia. However, certain facts emerge from these cases and are worthy of comment. We note that in the first case the patient regained slight use of her limbs 14 days after the initial attack. However, she was still completely mute. She did not react to simple questions asked of her. There was a dramatic response, however, after the first injection of sodium amytal; she began to utter sounds for the first time, and she appeared to be trying more than before. Even the family commented that she made continuous efforts to speak. We observed similar improvement in the second patient. They both improved after two repeated injections. However, additional injections appeared to have no influence upon the course of their speech.

It is apparent from the study of these patients that the use of sodium amytal brought about or hastened improvement in speech. Both patients appeared to be in better spirits and made a determined effort to improve their status after the first few injections. However, this was of temporary duration as no change was noticeable after the fourth injection in the first patient, and the second injection in the second patient. What is the nature of this action? Why is its efficacy, if it is, so ephemeral? Is it the drug, or would an injection of aqua pura have the same result? The author is unable to answer these questions. It would be interesting to try a series of cases using sodium amytal and plain distilled water for comparative purposes. However, I do believe that until many more cases are reported, our final opinion as to the efficacy of this drug should be held in abeyance. Therefore, we urge that physicians, especially the general practitioner who sees his patient first, should continue with this treatment.

Summary

1. The use of sodium amytal in the treatment of aphasia is reported.
2. The drug hastened improvement in speech, but was of temporary nature.
3. Both patients appeared to be in better spirits and made a determined effort to speak after the use of sodium amytal.
4. The final efficacy of this drug is held in abeyance until more extensive case histories are observed and reported.
5. Two cases are reported.

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SOME OBSERVATIONS ON SHOULDER DISLOCATION

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Shoulder dislocation is the commonest of dislocations and the subcoracoid type embraces three fourths of all shoulder dislocations. Dislocation of the shoulder is practically always caused by strong and sudden abduction of the arm. The head of the humerus can only leave its normal habitat in the glenoid fossa by tearing the capsule of the joint, the dislocation is immediately sub glenoid then usually subcoracoid.

Diagnosis: The history, the flattened deltoid, the x-ray make the diagnosis positive.

By x-ray is meant films, not fluoroscopy. A frac-

ture may be overlooked if fluoroscopy is depended upon, take films and good ones. Small weak outfits will not do. A good outfit with a Bucky diaphragm alone will give good detail.

Treatment

If the case is recent, that is within a few minutes, and the patient hardy, reduction may be effected without any anesthetic. I have been able to reduce half of my shoulder dislocations without the use of any anesthetic but a hardy cooperative patient is required for such a reduction.

Anesthetic

Chloroform has worked well and I have been able to make reduction without using more than an oz. and in some cases with less than an oz. It gives good relaxation. DaCosta condemns it, saying that it is particularly dangerous in shoulder dislocation.

Intravenous anesthesia is potentially dangerous and I do not use it at all.

Local anesthesia, Novocain 6 cc. of a 1% solution well placed will after a wait of 6 minutes by the watch, give fair relaxation and analgesia.

If the case is apt to be difficult, the patient timorous and non cooperative the old stand by, ether, is best, it never kills anyone and gives good relaxation.

With cooperation by the patient and the right technique, it may be possible to dispense with the anesthetic. If the patient is intoxicated he is narcotized and should not be given any form of anesthetic.

The methods of reduction employed usually are Kocher's, or Smith's or Cooper's. I have used Kocher's a number of times with success but do not like it. Kocher's method imposes additional trauma; it also carries the risk of adding fracture to the dislocation.

Sir Astley Cooper's method is by far the best. There is no twisting, nor rotating, just a good long, strong pull with the heel in the axilla of the dislocated shoulder and the operator pulling steadily and strongly.

There is no damage to axillary vessels as some have claimed, the heel levers the head of the bone back to its normal spot in the glenoid cavity.

Bohler of Vienna says in part "Fifteen years ago I abandoned the Kocher method and since that time I have used my heel." The same author roundly condemns "open" reductions.

Technique of Reduction

Patient on back on a low flat table or better still on the floor (the ordinary operating room table or a cart is absolutely taboo).

The operator places his left stockinged heel in the left axilla if the dislocation is left and vice versa if it is in the right shoulder.

He applies to his hands liquid adhesive and takes a firm grip on the patient's wrist and forearm and pulls steadily, gently insinuating his heel against the head of the dislocated humerus. The operator pulls strongly with an abiding faith that he will hear the welcome crunch which announces the reduction.

Delayed Reduction

Delayed reduction adds to the difficulty and danger of the dislocation, osteopores (Osteoporesis) develops rapidly in the unreduced case and thereby adds to the danger of fracture during the reduction.

Campbell states that he advises open reduction in a case that has gone five weeks unreduced. The same author states however that closed reduction often succeeds at a much later date.

In my own opinion if careful x-raying does not reveal cloudiness nor any bone destruction, closed reduction may be attempted as late as ten weeks post trauma.

Any such attempt should be with a full understanding of the hazards involved. The patient should be informed of the possibility of fracture, the operator should have the fullest and frankest discussion and before witnesses.

Nevertheless if the rays are clear Cooper's method should be tried before resorting to that surgical horror, an open reduction of a neglected shoulder dislocation.

I have seen two patients who elected to go through life with a dislocated shoulder rather than permit any kind of treatment by anyone.

The records of insurance companies constitute a startling indictment of the abuses of the "open operation." The results are often worse than no treatment at all.

Such practice will bring orthopedic surgery into an ill deserved disrepute and much credit is due to McKeever and Campble for their writings along these lines.

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GASTRIC NEURALGIA

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Gastric neuralgia is a symptom complex, a syndrome, due to numerous sensory, motor, and physical conditions. It is possibly the most frequent complaint superceding those of headache, dermal pruritis, and the intricacies affecting the lower spinal region. The volumes that have been printed, the ever-present discussions, the spirited debates, the infinite speculation, the ingenious methods of scientific investigations, the paradoxical conclusions, that have so profoundly activated the realms of gastric ulcerations,—neoplasms, and gastritis, shall be omitted in this brief presentation.

This plague, which is part and parcel of modern civilization, our mode of daily life, hurry, emotions, envies and ambitions, that victimizes those individuals possessing an unstable nervous temperament. The stomach, ever so sensitive, perpetually responding to nerve stimuli, manifests pain, when morbid or irritating conditions, affect the sympathetic nerve ganglia, the celiac plexus, the aortic plexus, and

the superior messenteric plexus.

There is a Biblical dictum, "The culmination of a Deed with Thought Begineth." The scores of conditions: gastric hyperesthesia, nervous anorexia, akoria, Bulimia, nervous nausea, gastralgokenosis, are sensory neuroses, with origin cephalic, in the abode of the higher cerebration. Indeed—the same can be expressed about the motor neuroses; hypermotility, cardiospasm, pylorospasm, aerophagia, nervous vomiting, pneumatosis, vagotonia, sympathicotonia, or derangements or irritation of the vagus, sympathetic, the vegetative nervous system, which in reality originate primarily in the cerebral cortex.

The frequent expression: "It gives me a pain in the stomach;" "I can't stomach it;" "it turned my stomach;" " it knocked out my stomach," illustrate the gastric consciousness of many. In episodes of emotional distress, excitement, or bad news, many people clasp their hands to the abdominal wall. A person of good sparkling health and cheerful disposition is described as "having a good stomach," "able to digest nails," "can eat a horse."

The nervous attacks of gastric pain occur periodically of varying intensity, mild or very excruciating, lasting hours or days, radiating posteriorly or anteriorly, to the thorax, or abdomen, epigastric, or umbilical region. These pains are usually initiated by nervous excitement. In some cases the gastric pain is due to abnormal sensitiveness of the mucosa to chemical, mechanical or termic stimuli. Certain food articles, or cold drinks, cause fullness, burning, pressure, distressing cramps, and subside when leaving the stomach. Also gastralgia may develop when the stomach is empty. Frequent and powerful hunger sensation, exceeding the normal state, giving a gnawing pain, fainting sensation and headache. The well known condition, anorexia nervosa, although painless, is due to mental depression as hysteria, neurosthenia, worry, and fright. Also on the same basis, although paradoxical, the gastralgia encountered in the loss of satiety sensation, a polyphagia, where the intake of food is enormous. Nervous nausea, aversion to food where the stomach function is normal, is mostly a neurotic state. The various forms of motor neuroses, the mental factor is powerful in neurasthenics, hysterical, and the hypochondriacs. The nervous mechanism which is complex, loses its equillibrium, producing hypermotility, hypomotility, spasm, atony, hypersecretion, or hyposecretion. Although the vagi, sympathetics, the plexuses of Auerbach and Meisner, the vegetative nervous system are isolated, still the main impulses originate in the central nervous system. The pain regions are very often epigastric, above or below the navel, appear periodically independent of food intake, precipitated by nervous excitement and occasionally accompanied by vomiting and belching. It must be understood that the pains mentioned in the various conditions are to be considered as mostly extragastric.

The diagnosis of gastric neuralgia should be made only after a most careful investigation,—excluding any possible pathology, X-ray, fluoroscopy, gastrophotography, gastroscopy, gastric and fecal analysis. The points of tenderness on pressure are epigastric in distribution, in the median line, above or below the umbilicus. The zone of pain is extragastric and occupies a larger area than ulcer. There is usually no hyperchlorhydria, no occult blood, or relief by food or alkali. However, it is impossible, or extremely difficult to differentiate such conditions as "ulcer syndrome," "phantom ulcer," "evanescent ulcer," and gastritis. Also there is no seasonal accentuation, but preceded by a nervous upset, fatigue, and fright.

Other etiologic factors causing gastric neuralgia reflexally, are gallstones, chronic appendicitis, adhesions, and pancreatitis. Syphilis, especially the latent type, with negative blood and spinal fluid, and other physical findings, but with a gastric neuralgia persistent, very distressing, not yielding to any treatment. This possibly may be a gastric crisis, without any other tabetic signs. Many cases like these are found in elderly or middle aged, who had syphilis, but cured under intensive specific therapy, but the gastralgia remained. Here, enormous dosage of penicillin is of no avail. Large doses of niacin has been claimed to be of some advantage. These are cases, that should be termed, residual post syphilitic gastric neuralgias, or luetic gastralgia.

Chilling of the stomach by intake of ice cold fluids, and exposure of the abdominal wall to cold, windy atmosphere, produces dull gastric pain covering a large area. Lead toxicity, characterized by lead colic, where the abdomen is hard, drawn inward, lasting several minutes. Here a history of handling lead, painting, and a blue line around the gums are present. A foreign body in the stomach, as a phytobezoar, trichobezoar will cause pain, and could be recognized by X-ray and gastroscope. Gastric anamolies, malposition which nature can't compensate, constitutional gastric inferiority, especially in the asthenic, with visceroptosis, where there is relaxation of the visceral smooth—musculature, messenteric anamolies will produce pain.

A hereditary element is often found in many patients. Organic diseases of the nervous system, where vital nerve centers are involved, by tumors, infection, degeneration, or secondarily by pressure. Gastro-intestinal allergy, and food sensitiveness, cause much gastric distress, especially in children. Esophageal hiatus herniae produce pain, regurgitation, heart burn, bad taste in the mouth, when assuming a certain position. The same is true in diverticulosis of the stomach and in congenital or acquired diaphragmatic hernia. In many instances, gastric neuralgias are secondary affections and may come in the course of almost any disease of the stomach, intestine, or other abdominal organs, in arteriosclerosis, diseases of the male and female sexual organs, anemias, toxemias.

The treatment is a painfully difficulty undertaking, a Herculean task, demanding of the physician to be a diplomat, psychiatrist, sociologist, philosopher, patience of a Job, tact, unlimited understanding, and sympathy. To treat such individuals the physician faces social complexities, hereditary traits, mental and physical abnormalities, economic difficulties, and various other obstacles created by modern living. It means to reclaim one from the mounds of human wreckage, to reconstruct from the social debris, a being fit to act, live and face the environmental world. Reassurance of the patient, dispelling apprehension, by explaining the nature of a neurosis and its differentiation from organic disease, are extremely helpful. To imbue the patient with cheerfulness, sunny hope and optimism, are the prime paths, leading to successful treatment. To establish mental tranquility in such cases is the foundation of the art of healing. Appropriate stress should be laid to such features, as strain, fatigue, removal of exogenous, endogenous, bacterial toxins, the role of endocrines, and heredity.

Rest, plenty of sleep, noon rests, hospital bed rest, long vacations, physical training, swimming, golf, and outdoor walking. Change of climate and surroundings, sojourns in health resorts are beneficial. Sympathetic treatment to control some or partial complaints aid to establish confidence.

Sedation temporarily employed until sleep, and mental serenity are established. Drugs like bromides, barbiturates, chloralhydrate, belladonna, should be used. When the pain is severe a hypo of codeine, demerol, and morphin should be used. Small doses of paregoric, valerian tea, chloretone, and benzocain are useful.

Psychotherapy: An experienced physician who will listen to the patient's troubles and complaints, willing to answer his questions, to guide and help changing his introspective and disjointed viewpoint to an orderly and confident outlook on life. It is very essential to advise the patient to mingle socially, to participate in community affairs, social work, in order to widen the horizon of daily life, and to make him forget his ego, by helping others, and keep the mind busy.

It is good practice to keep detailed records of every visit, weight, progress of symptoms, complaints, which are useful to the physician and impresses the patient. Haradic, and galvanic electrical therapy, hot applications, and massage should be tried.

Very little or no restrictions need be made in regard to diet, although milk diet for a brief period may help. It is not necessary to keep the patient on a fluid diet or light diet. It should be amply nutritious, and digestible. It is necessary to encourage eating, explaining that there is harm by abstaining from food. The use of multi-vitamins, liver and iron are beneficial. The omission of alcohol, tobacco, strong coffee, or tea is advisable.

All activities that call forth nervous excitement, as card playing, late hours, visiting horse races, boxing and wrestling exhibitions, should be curtailed.

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Veterans Administration Center

Thiamine Chloride and Neostigmine Bromide For The Treatment of Angina Pectoris

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During the past four decades, the incidence of Heart Disease has been steadily mounting. In the year 1900, Heart Disease ranked fourth as a cause of death, while to-day, it has assumed first place. (1)

Coronary artery disease is well represented statistically in this rising lethal tide. This disease, because of its associated angina and anxiety is notoriously prominent as a cause of disability in all walks of life.

The preliminary work on the combined use of thiamine chloride and neostigmine bromide for the relief of anginal pain has been sufficiently encouraging to warrant a report at this time.

A group of nineteen patients were selected for treatment. The first five patients were given a tablet of thiamine chloride 50 mgm. before meals, and a tablet of 15 mgm. of neostigmine bromide after meals. Within one to three weeks of administration abdominal cramps were produced in all of the cases, therefore, atropine sulphate 1/150 gr. was incorporated with the thiamine and neostigmine into a single capsule, given three times a day, after meals. All the cases have regularly taken this capsule for a period of five weeks to three and a half months, and with no deleterious reaction produced in any of them. The ages of the patients varied from 31 to 67 years, fourteen males and five females. Thirteen patients belonged to the arteriosclerotic group; four were rheumatic; one hypertensive; and one luetic.

There were eight patients in the *arteriosclerotic group* with a daily complaint of pain varying from typical angina with precordial pain and radiation to the left arm, to those with substernal oppression. Five patients in this group complained of anginal pain intermittently. Eleven patients of this series had one or more attacks of coronary occlusion with electrocardiographic evidence of infarction.

The four patients in the *rheumatic group* had frequent daily attacks of angina, and all of them had aortic stenosis, and insufficiency in addition to their mitral lesion.

The one *luetic* patient had frequent severe attacks of typical angina which required morphine administration for pain.

The one patient with *hypertensive* coronary artery disease had multiple attacks of angina daily, he also had electrocardiographic evidence of a previous coronary occlusion.

Explanatory Table #1

Case #	*Patient*	*Sex*	*Age*	*Disease Type*	*Previous Coronary Thrombosis*
1	H. M.	M.	52	Arteriosclerotic	Yes
2	S. R.	M.	60	"	Yes
3	L. G.	M.	53	"	No
4	M. T.	M.	67	"	Yes
5	H. F.	M.	53	"	Yes
6	S. L.	M.	54	"	Yes
7	L. C.	F.	56	"	No
8	A. K.	M.	66	"	Yes
9	M. S.	M.	31	"	Yes
10	D. B.	M.	54	"	Yes
11	P. K.	F.	59	"	Yes
12	I. M.	M.	52	"	Yes
13	E. K.	F.	60	"	Yes
14	M. K.	M.	56	Rheumatic	No
15	M. S.	F.	56	"	No
16	J. S.	M.	59	"	No
17	M. K.	M.	59	"	No
18	A. C.	M.	52	Hypertensive	Yes
19	M. M.	F.	36	Luetic	No

Explantory Table #2

Case #	*Patient*	*Daily Req. Nitroglycerin Before-After*		*Duration of Treatment*
1	H. M.	2	0	3½ months
2	S. R.	1	0	3½ "
3	L. G.	2	0	3 "
4	M. T.	3	0	2½ "
5	H. F.	1	0	2½ "
6	S. L.	1-2	0	3 "
7	L. C.	1-2	0	9 weeks
8	A. K.	1-2	0	7 "
9	M. S.	1	0	7 "
10	D. B.	1	0	8 "
11	P. K.	3-5	0	7 "
12	I. M.	3	0	2½ months
13	E. K.	2	0	5 weeks
14	M. K.	1-2	0	7 "
15	M. S.	2-3	0	2½ months
16	J. S.	1-2	0	5 weeks
17	M. K.	15-20	1-2	6 "
18	A. C.	8-10	0	3 months
19	M. M.	Opiates	0	2 "

Result of Treatment:

The relief of pain was rapid and dramatic in all patients treated, irrespective of the etiology of the anginal pain. Patient #6 was given an additional dose of medication at bed time because of a complaint of substernal oppression at night. He was completely relieved of his complaint by the night dose. Patient #18 had an occasional mild attack of anginal pain on three dose schedule, but he has been completely relieved by the administration of five doses daily given at four hour intervals. Patient #17 required 15 to 20 nitroglycerin tablets daily before onset of treatment for the relief of anginal pain, but at the end of a week he resorted to 1 to 2 nitroglycerin tablets daily. His dosage was recently increased to five capsules daily, and it is hoped that this may entirely eliminate his need for nitroglycerin. Patient #19, a colored female with luetic aortitis, had frequent attacks of typical angina which necessitated the administration of morphine hypodermically for relief. She has been on medication for two months without a single attack of angina since the initiation of her therapy.

In addition to the marked improvement in the anginal syndrome, all of the patients have developed a sense of well being, increased psychomotor activity, and improved tissue oxygenation as evidenced by the disappearance of skin pallor. Despite the increased activity of these patients who find themselves relieved of their anginal pain, there has not been a single instance of coronary thrombosis or cardiac failure up to the present time.

This group of patients are being studied objectively by serial electrocardiograms, and repeated vital capacity determinations, the results of which have not as yet been completed. In addition, a study on a much larger series of cases is contemplated. More study will be given to individual dosage requirements, and an attempt will be made to evaluate the permanency of reilef when medication is discontinued.

Rationale Of Treatment:

Agid, Beauvallet, and Minz, (2) have demonstrated that thiamine chloride will prolong and reinforce the action of acetylcholine on the isolated intestine of the rat, and the blood pressure of the cat. Bernheim, (3) states; that thiamine has twenty-six times the affinity of acetylcholine for cholinesterase, and therefore, becomes a powerful esterase inhibitor.

It has been noted in thiamine deficient states that the carbohydrate metabolites, lactic acid, pyruvic acid, and carbon dioxide tend to accumulate, and with the augmentation of these products the oxygen saturation of the tissues is lowered, and signs of anoxemia may appear.

Vitamin B-1 deficiency is frequently present in individuals whose appetite for food is impaired by excessive smoking or alcoholic indulgence. The higher incidence of coronary artery disease in smokers has been observed by many clinicians. W. J. McCormick, (4) states; "Clinical application of intensive vitamin B-1 therapy in a considerable number of cases of incipient coronary disease has brought about striking improvement in all prodromal symptoms." Bernheim, (5) experimenting with neostigmine, found it to potentiate acetylcholine, and to augment the action of the latter. Neostigmine exerts its action by inhibiting cholinesterase. Perlow, (6) working with prostigmine in peripheral circulatory disturbances, is of the opinion that this drug is of value in circulatory diseases in which there is

the element of vasospasm. Abramson & Associates, (7) using prostigmine, were able to increase the flow of blood to the hand as much as 2½ times in four out of seven instances.

Acetylcholine, a choline ester $(CH_3)3N(CH)CH_2.CH_2.O.C.O.CH_3$. which is normally present in many parts of the body, is the integral chemical mechanism responsible for parasympathetic nerve function, and is liberated at the synapses and myoneural junctions when an impulse passes through the parasympathetic system. In addition, acetylcholine has a vasodilating effect upon peripheral blood vessels. Cholinesterase, an enzyme, present in all body tissues is directly antagonistic to the presence of acetylcholine, and readily hydrolyzes this choline ester into choline and acetic acid.

The experimental work of Agid et al., and Bernheim, reveals that both thiamine and neostigmine augment the production of acetylcholine by inhibition of cholinesterase. The beneficial effects on anginal pain produced by thiamine and neostigmine may be due to the vasodilating effect of acetylcholine upon the coronary vessels. Still another explanation can be postulated; the production of anginal pain may be conditioned by the presence of strong adrenergic stimulation of the coronary arteries in a system which lacks an equal flow of cholinergic impulses to balance the former. Thiamine and neostigmine by its energetic stimulation of the parasympathetic nervous system may permit a balancing of forces against previously existing adrenergic preponderance, thereby overcoming coronary vasospasm.

Summary

(1) A preliminary report is here presented of a series of nineteen patients with Cardiac Disease and Angina.

(2) The group includes patients suffering from severe and frequent attacks of anginal pain of varying etiology.

(3) The relief has been rapid and dramatic in every instance.

(4) The combination of Thiamine Chloride and Neostigmine Bromide apparently sets up a strong cholinergic action by enhancing acetylcholine metabolism with a resultant balancing against previously preponderant adrenergic stimuli, thereby relieving coronary vasospasm.

(5) Also, the possibility of the beneficial results produced may be ascribed to the vasodilating effects of the high concentration of acetylcholine induced by Thiamine and Neostigmine.

(6) It is hoped that further study will substantiate the preliminary work, and add a worth-while weapon against this agonizing scourge of mankind.

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OPEN FORUM

BRAIN FOOD

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Many years ago a genial Scot with whom I worked told me: "If I occasionally appear stupid, just attribute that to the fragments of oatmeal which lodged in my mushpan as a child!" He apparently did not look upon this traditional cereal as brain food.

Quite recently one of the three thousand persons who wrote an inquiry to the U. S. Department of Agriculture which arrived during a single normal day, betrayed her anguish as follows: "Somewhere I have read about a plant that would make you very intelligent if you ate it. Could you tell me where to buy the seeds of this plant so that I could grow some? I know this sounds crazy, but I mean it."

What about brain food? Can you so eat as to fortify or increase your intelligence? Can you consume such foods as will develop your brains when you started with very little in the first place?

A generation or two ago Mom conscientiously fed us fish because it was brain food. It seemed that both fish and our brains contained phosphorus. But the fallacy was exploded by the finding that fish phosphorus did not go directly to the brains and make us wise.

But possibly if we tried to eat as wise men ate we too could become wise? Which reminds us that the philosopher, Herbert Spencer, practised strict vegetarianism for a while, then concluded that this had impaired his mind and burned all he had written under the inspiration of carrots and cabbages.

Luther, Goethe, and Sir Walter Scott were all hearty trenchermen. Dr. Johnson discoursed learnedly on the necessity for minding his belly studiously. Boswell describes him as eating with fierce intensity, until the veins stood out on his head, and he broke into a profuse per-

spiration. He refused even to converse until his appetite was satiated.

Should we eat thus to grow wise? Not necessarily. The great philosopher Kant ate slowly and delicately, taking three hours to consume his dinner. Carlyle's biliousness was attributed to overindulgence in ginger-bread, according to some of his physicians. Lord Byron lived for long periods on biscuits and soda to reduce his weight. Victor Hugo, who lived to be 83, had the appetite of an ogre in his seventies.

Evidently this will not add up to answer our question. Suppose then we turn to science and see what it has to say.

There are records in the scientific literature of undernourished children who showed far greater mental acumen than those who were well fed. But these are directly contradicted by other records of children whose grades improved when they became beneficiaries of the government's School Lunch Program.

About twenty years ago a physician studied the intelligence and diet habits of five thousand school children, seven hundred of whom he followed on through school and college, and into business life. He insisted that their I. Q.'s increased when they were consistently fed better. In short, seven months of eggnogs paid off by improving the intelligence of nine out of ten children who came from families where a high intelligence was apparently hereditary.

This doctor wound up by claiming that 95 per cent of the low-grade intellects were aggravated by bad surroundings and poor food. He said that many individuals had been convicted of crime solely because they lacked the intellect to escape detection! Whether he thought an improved diet would recondition their morals or merely enable them to become more proficient criminals it is difficult to say.

Many of the scientists limited their study largely to their favorite animals, rats. One, a Hungarian, claimed that rats suffering from vitamin deficiency did not have lighter brains than their fellows who received sufficient vitamins.

Another—an American, discovered that rats were more active when poorly fed, and they excelled well-fed rats in solving mazes, largely because hunger made them more active and they tried harder. He was promptly contradicted in part by another American who declared that his ill-fed rats took somewhat longer to find their way through mazes, but made fewer errors than the well-fed.

Quite recently certain investigators at Columbia came up with the discovery that feeding glutamic acid—one of the score or more of substances that go to make up proteins—to children increased their I. Q. It also did the same thing for rats, in a manner of speaking.

Mentally retarded patients, some with a tendency towards epileptic seizures, were used in further experiments. Tests were made of memory, intelligence, manipulative skills, and personality. It was claimed that these individuals gained rapidly in intelligence while fed glutamic acid but lapsed quickly without it. Dull and inattentive subjects also became alert and attentive.

The workers theorized that brain tissue could metabolize and use glutamic acid directly. Maybe that is why it proved so much superior to the phosphorus in Mom's fish.

It was also a group of Columbia workers who reported in 1943 that supplementing the diet of children with thiamine, one of the vitamin B complex, improved the learning capacity of some very cooperative children. They were paired off into two groups, one of which got thiamine and the other a placebo. Regardless of what they got they claimed they felt better. Their diet, environment, and other factors were kept under control as well as possible. It finally appeared that the thiamine group was at least 27 per cent superior to the group not getting thiamine.

That looked pretty conclusive, until 1947, when another research team repeated the work, this time using 44 pairs of identical twins, and making tests at the end of 136 and 273 days. Some of these children were already obtaining as much thiamine in their diets as nutritionists recommend, some more, and some less.

At the end of the shorter period the group receiving extra thiamine had made greater gains in weight and height, and also seemed slightly superior to the controls in retentive memory and manual dexterity. No differences could be detected, however, in reasoning, rote memory, code substitution, eyesight, intelligence, reading, or arithmetic.

But here is the pay-off. At the end of the longer period no significant differences whatever could be detected between the two groups! Hence short-term experiments with groups of human beings not of the same genetic composition as are identical twins cannot be depended upon.

So in all essentials we are still about where we were when Mom fed us the fish. We know no substance that will surely improve the mind if regularly eaten. We simply know that the mind, like the body, is improved by a scientifically balanced diet, and that undernourishment does not pay either physically or mentally.

Granite Gables.

Book Reviews

Urology

Urology for Nurses. Nurses' duties and responsibilities in the total care of the urologic patient. By OSWALD SWINNEY LOWSLEY, M.D., F.A.C.S. Director of the Department of Urology (James Buchanan Brady Foundation) of the New York Hospital, and THOMAS JOSEPH KIRWIN, M.D., F.A.C.S., Attending Surgeon, Department of Urology (James Buchanan Brady Foundation) of the New York Hospital. Philadelphia, London and Montreal: J. B. Lippincott Co., 1948. 637 pages and index and glossary. Price $6.00

Two preeminent authors in the field of urology and urological surgery have presented us with the second edition of a most helpful book. The text is intended for the professional nurse, but the physician and the surgeon may read with profit. The information is most timely. The general physiology, anatomy and surgical preparations given of value to all. The special sections on setting up for operation and the nurses and the nurses part in the care of the patient are neatly put.

The text is in the two column style. Adequate illustrations are given. Suggested examination questions are found at the close of certain sections. A Glossary of Terms used in Urology is very helpful.

Management of Common Gastro Intestinal Diseases. Edited by THOMAS A. JOHNSON—published by J. B. Lippincott Company, Phila., Pa.

A score of super specialists prepared and submitted complete although short articles on phases of diagnosis and treatment of the patient with gastro intestinal symptoms. It all forms a compact whole under the able Editor. The publisher has furnished almost excellent book-paper-type arrangment and size. One can hardly believe the text has almost 300 pages.

The physician in any form of medical practice will find some chapter of value during the course of a busy office session. It may be a quick glance to refresh the memory on Chronic Gastritis, or fifteen minutes on the chapter on Viral Hepatitis. The Diagnosis and Treatment of Irritable Colon deserves several periods of reading.

All and all a very serviceable book.

Medication

Technic of Medicine. Practical working guide to expedience, efficiency, and economy in drug administration. By AUSTIN SMITH, M.D., Director of the Division of Therapy and Research; Secretary, The Council on Pharmacy and Chemistry, The American Medical Association. Philadelphia, London and Montreal: J. B. Lippincott Co. 248 pages and an index. Price $4.00.

This book has a long and excellent history. The late Prof. Fantus was responsible for three editions of the work under a longer name. Dr. Smith, Director, Division of Therapy and Research, and Secretary, Council on Pharmacy and Chemistry, American Medical Association has done a good job in this edition. All the facts are there—each under the right heading, as General Consideration in Medication, The Prescription, Oral Administration, Parenteral Administration, Rectal and Genito Urinary Administration, Application to the Skin, Mucous Membrane Applications, and Some Practical Aids.

But the book despite the good things one can say about it—lacks that something. It just falls short of being indispensable to the busy practitioner. He does find the facts—no book deserving the cooperation of Dr. Morris Fishbein lacks facts. However, the physician will not find ready prescriptions to copy and send off with the patient to the pharmacist. A review of this book is worthwhile, however, for the physician contemplating the patient with an ailment he may be called upon to treat in his practice.

Victor Robinson

Victor Robinson Memorial Volume. Essays on History of Medicine. Edited by SOLOMON R. KAGAN and by 40 medical historians. Froben Press, Inc. New York, 1948. 447 pages. Price $10.00.

During his life time, the friends of Prof. Victor Robinson planned an Anniversary Golden Book for presentation on his 60th birthday. But, alas, it was to be otherwise. The man was dead. His voice stilled. His pen quiet. But, the friends were not dismayed. The volume makes its appearance now. A memorial volume, no less. His own published works listed in the last few pages of this book are Victor Robinson's best memorial. The mode of his writing has never been equalled and it will be long before another comes this way.

But we are far afield from the volume before us. The contributions are published according to the abc of the contributor. In this manner, no one is first and no one last although it makes for a slightly confusing book. The topics suitable for juxtaposition are separated by the chance of authorship.

A number of published notes on Victor Robinson at the time of his passing are reprinted giving a four sided version of the man. His sister, Mrs. Ringer also adds a note. The picture reproduced as a frontpiece is excellent.

The friends of Victor Robinson have honored themselves in submitting their contributions. Historians will probably find a little nugget here and there. The physician practicing medicine will find newly opened vistas as to the way in which man past and present regarded this profession.

Polio

Polio and Its Problems. The challenge of poliomyelitis. By ROLAND H. BERG. Philadelphia, London and Montreal: J. B. Lippincott Co. With 24 illustrations, 164 pages and an index. Price $3.00.

This is a book written expressly for the lay

(*Continued on page 22*)

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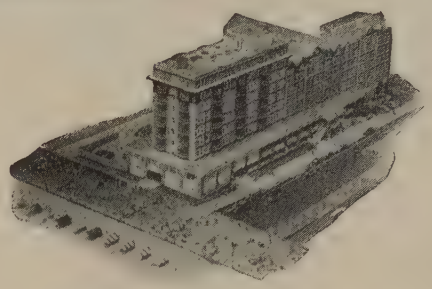

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(*Continued from page 20*)

public in simple, easy-to-understand language on a subject which is of the utmost importance to a great many individuals—polio. It is the story of what has been done since 1916 when the first epidemic of infantile paralysis hit the headline of the newspapers of the nation. Mr. Berg writes in a very vivid style and he reveals a dramatic cavalcade of tireless research, perilous experiment and great persistence as science answers the challenge of poliomyelitis. He tells of the triumphs and disappointments of research medical workers who for many years have attempted to find the cause and cure of this dread disease.

In this book are considered the answers to such questions as: Is there but one virus causing infantile paralysis or are there many forms? What are the pathways of infection? Where does the virus hide in nature? What animals or insects harbor it in their bodies? What diagnostic methods can best reveal the "healthy carrier"? How many of its peculiar characteristics must be uncovered before science can hope to solve its riddle? This book is one that every doctor can recommend to his patients who are victims of this disease and to the parents of children who have become afficted with polio. It will give them a great deal of valuable information.

Fractures

Fractures and Dislocations. By BARBARA BARTLETT STIMSON, A.B., M.D., Med. Sc.D., F.A.C.S., assistant professor of Clinical Orthopedic Surgery, College of Physicians and Surgeons, Columbia University, New York City; associate attending surgeon, Presbyterian Hospital and Vanderbilt Clinic, New York City. Second edition, thoroughly revised, 98 illustrations. Philadelphia, Pa.: Lea & Febiger, 1947. Pp. 223. Price $3.25.

This handbook contains a wealth of material on fractures and dislocations encountered in everyday practice. It offers a guide to the principles of treatment and selects pertinent methods in applying those principles to specific lesions. After a preliminary classification of fractures, symptoms and signs are presented to emphasize diagnostic criteria. Then details of technique are given invaluable for the general practitioner. From the general survey of the subject there follows a series of chapters on the skeletal system from head to toe giving first-hand procedures for every type of fracture or dislocation. The approach is unique, the illustrations clear and the information succinct.

Diagnosis

Diagnosis in Daily Practice. By BENJAMIN V. WHITE, M.D., assistant clinical professor of medicine, Yale University School of Medicine; consultant in Gastroenterology, Veterans' Administration Hospital, Newington, Conn.; CHARLES F. GESCHICKTER, M.D., professor of pathology, Georgetown University Medical School; consultant in pathology, Mt. Alto Veterans' Administration Hospital, Washington, D. C. 360 illustrations. Philadelphia, Pa.: J. B. Lippincott Co., 1947. Pp. xvi + 693. Price $15.00.

This well illustrated addition to our diagnostic armamentarium is invaluable in everyday practice. The physician is primarily responsible for the management of those illnesses which are the major cause of disability and death. Consequently, he should hold himself accountable for the prompt recognition and handling of the predisabling phases of such diseases in order to prevent more drastic complications. The author brings to the foreground of medical consciousness the major causes of disability and death and thus emphasizes the group of disorders which constitute the major medical concern in everyday practice. Physical examination has been derived from an analysis of the prevalent early findings in each of these major diseases. This enables the physician to rule out the presence of all the common diseases with a degree of accuracy commensurate with the present achievements of medical science. The abnormal is to be sought on routine examination together with the supplementary procedures to be undertaken in the presence of positive routine findings. They are given in diagramatic form for quick reference. Other chapters consider diagnostic abnormalities individually from the standpoint of pathology, physiology and laboratory procedures. There are also tables for each abnormality relating to the differential diagnosis of the major diseases. The book is divided into five parts, the first gives the diagnostic survey, the second symptom diagnosis; third, physical findings; fourth, laboratory procedures; fifth, a systematic survey of the major diseases and diagnostic implications. The book is a veritable eye-opener for diagnostic possibilities in the evaluation of a patient. All aspects of medicine are integrated in the cause of early and accurate diagnosis.

Antibiotics

A-B-C's of Sulfonamide and Antibiotic Therapy: By PERRIN H. LONG, M.D., F.R.C.P. Professor of Preventive Medicine, The John Hopkins University School of Medicine Philadelphia and London: W. B. Saunders Co., 1948 226 pages plus an index.

This is a small but very thorough compendium provides concise, up-to-the-minute, easily available information concerning the practical aspects of the use of chemo-and antibiotic therapy in the treatment of infectious disease. The clinical pharmacology, toxicity and methods of administration of these agents are discussed, as well as other general aids to their use. Every necessary phase of the subject is covered. Each clinical condition is then individually discussed as regards its etiology, its specific and auxillary therapy, and as regards other important comment. There is, however, no particular discussion of the topical use of these agents, either because this thought is unnecessary, or, because in certain instances, the author considers it harmful. The book should be a valuable addition to the practitioner's row of books on his desk for quick reference.

Editorial

Importance of Chest X-Rays During Pregnancy

Tuberculosis contracted during pregnancy always carries an anxious prognosis for the *accoucheur*. There may have been a healed or closed lesion which lights up during gestation as the result of a respiratory infection said to be "just a cold." In any case the profound physiological changes which take place in a woman's body when she is *enceinte* may be complicated by many undesirable conditions such as destruction of the teeth through loss of calcium, or acute yellow atrophy of the liver. We are not always able to forestall these events, but we know that we must be on the alert and diagnose them as early as possible. Women who exclaim that they 'never felt better in their whole lives' are the ones who may suddenly develop an astonishing and irreversible ailment.

Pulmonary tuberculosis is one of these, and it may have an extremely insidious onset; therefore, one should examine the chest as a part of the routine entailed by those visits to the doctor which are so important a part of the monthly physical checkup. Since early diagnosis by stethoscope of "a spot on the lung" may be difficult, even impossible, fluoroscopy or roentgen photography should be added to present-day routine. This fact has been brought forcibly to this writer's attention by a letter from a mother which was published in the NEW YORK TIMES on July 30, 1948.

Seldom do we find such an intelligent analysis of a situation by a non-medical person, who, without bitterness or rancor, calmly states that five weeks after the birth of her second baby, she was found to be suffering from "moderately advanced pulmonary tuberculosis." She declares that her family doctor was a competent general practitioner. Moreover she was under the care of "a good obstetrician." Some one directed her to an ear, nose and throat specialist who diagnosed "an infected sinus" for which condition the patient was put to bed for some weeks under penicillin treatment. She says that she suffered from a persistent cough and was constantly tired,—symptoms which in retrospect must seem obvious at this time. No mention is made of a sputum test, nor of the now well-recommended

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CBG procedure. It seems that all three doctors were apprised of the symptoms, but each of them assumed that another had taken up the possibility of a Koch infection. All of this proves how susceptible each and every one of us is to errors of omission. We know that sinusitis with constant flow of secretions into the nasopharynx may cause cough, a feeling of fatigue, loss of appetite and a low-grade fever. Such a sinus infection is not difficult to diagnose, but if it seems to be unyielding, and there is tussis with expectoration, one should go "below the thyroid" to make sure that there is not also a lower respiratory infection, tuberculosis, but due to other well-known organisms strep; staph; etc. are often found in a "bronchitis."

This patient states modestly that her experience is not a matter of general interest insofar as it concerns herself only, but becomes such when one realizes that it may be neither unique nor uncommon. "It might serve as a warning and possibly save some other mother from a similar disaster." As bitter as the pill may be for organized medicine to swallow, we all should take it and profit by the testimony of a frank and unembittered witness like this one. This is especially the case when we reflect how the enemies of "the medical trust" can gloat over such a happening, and how the protagonists of socialized medicine will use it as an argument for the setting up of a bureaucracy under which doctors will be hirelings, subject to punishment or dismissal for their shortcomings. Something too must be said about the "specialists" who proudly proclaim that such and such "is not in my line." A doctor of medicine should be interested in his patient as well as in the diseases which he hopes to prevent or cure. Symptoms which seem to lie outside of a given field will interest somebody who *is* working in that field, and everyone of us has a colleague to whom we may refer our patient with the expectation that an effort will be made to solve the problem, if there is one.

In conclusion one can scarcely do better than to quote the final paragraph of this very sensible communication: "I feel that the Tuberculosis Association [The National Association for Tuberculosis and Health] should work to have the chest X-ray made as much a part of standard pre-natal care as the blood test is now. And I would urge all prospective mothers to insist on an X-ray, for only thus can they be sure of safeguarding the health of themselves and their families at a time when they are apparently especially susceptible to the tubercle bacillus. A. K."

It may be embarrassing to a practitioner to have a patient "insist" on having an examination which should be a part and parcel of every good physical examination. This insistence will never be necessary if one is willing to learn from an experience such as is recorded here.

These two Greek words combine as *androgen*, the male hormones which induce the secondary sex characteristics and psychic differences between male and female... such as "drive," "ambition" and "urge." These manifestations are largely dependent upon the ability of the testes to secrete the male hormones.

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ETHICAL—RELIABLE—SCIENTIFIC

Disorders of the Nervous System

BEAUTIFUL—QUIET—HOMELIKE—WRITE FOR BOOKLET

FREDERICK W. SEWARD, M.D., Director FREDERICK W. SEWARD, M.D., Resident Physician CLARENCE A. POTTER, M.D., Resident Physician

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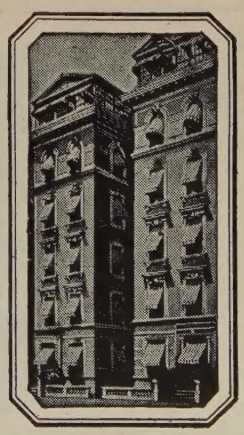

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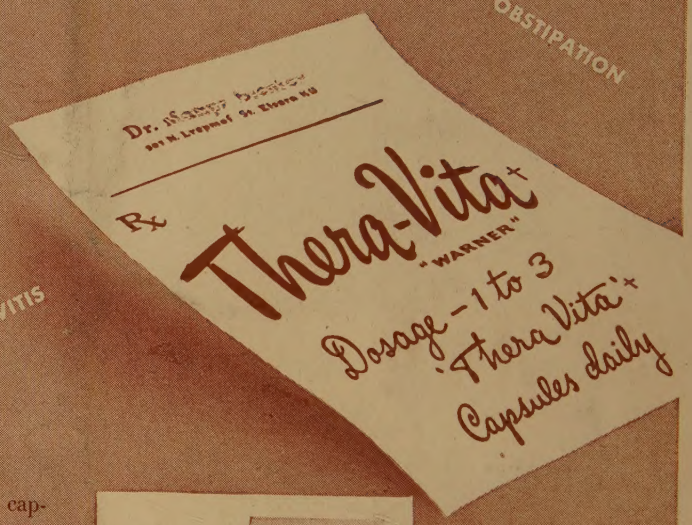

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